STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL HEALTH CARE CENTER	**1747 N RURAL ST INDIANAPOLIS, IN 46218**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00192908.

Complaint IN00192908 - Unsubstantiated due to lack of evidence.

Survey dates:
February 9 & 10, 2016

Facility number: 000388
Provider number: 155807
AIM number: 100454140

Census bed type:
SNF/NF: 42
Total: 42

Census payor type:
Medicare: 2
Medicaid: 38
Other: 2
Total: 42

Sample: 3

Rural Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 162-3.1 in regard to the Investigation of Complaint IN00192908.

QR was completed by 99993 on 02/11/16.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE